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Mr. Kerry Weems
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-2213-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Weems:

As Director of the Arizona Health Care Cost Containment System (AHCCCS), I am pleased to submit comments on the proposed regulations regarding the clarification of outpatient clinic and hospital facility services and the upper payment limit (UPL), published at 72 Federal Register 55158 (September 28, 2007). AHCCCS is the state agency that administers Arizona's Medicaid program, which covers over one million members.

As written, the proposed rule could have an impact on Medicaid reimbursement for outpatient hospital services and would more narrowly define outpatient hospital services, restricting mandatory approaches to calculating UPL for outpatient and clinic services. As a result, hospitals could receive lower payments since some services would no longer be reimbursable as outpatient hospital services, nor would they be included in the calculation for outpatient hospital UPL or disproportionate hospital payments (DSH). Additionally, CMS proposes to reduce states' flexibility in calculating the UPL applicable to private clinic services, requiring the use of Medicare fee schedules as the limit rather than actual costs.

Definition of "Outpatient hospital services"

CMS proposes to clarify what is described as "current vague regulatory language" for outpatient hospital services. CMS has concerns that the current broad definition overlaps with other covered services, resulting in higher reimbursement for identical services than would otherwise be available under the State Plan.

The proposed rule would limit the scope of services by excluding: 1) any service not treated as outpatient hospital services under Medicare; 2) services not provided by the hospital facility; and 3) services covered elsewhere in the State Plan- examples provided include are school-based services, adult day health and rehabilitative services, and services paid for under a fee schedule.

Although states would be allowed to continue covering services excluded from the proposed narrow definition of outpatient hospital services, they would not be permitted to reimburse them as outpatient hospital services. Additionally, under current CMS policy, services excluded from the narrowed definition of outpatient hospital services would no longer be eligible for DSH reimbursement because they would not be considered costs incurred by a hospital.

Definition of "Outpatient Hospital"

Under the proposed rule, services can only be included in the outpatient hospital UPL if they meet the proposed definition of "outpatient hospital services" and appear on the outpatient-specific cost report worksheets. The Medicare standard for outpatient hospital services is more specific, particularly with regards to the settings that would qualify. The Medicare criteria for "provider-based status" is a complicated standard. As a result, some hospitals that are claiming a facility fee would only be eligible to receive payments for the professional services, not the facility charges.

Additionally, the proposed rule requires that in order to qualify as outpatient services, the service must be "furnished by an outpatient hospital facility, *including* an entity that *meets the standards for provider-based status* as a department of an outpatient hospital set forth in §413.65 of this chapter." 72 Fed. Reg. 55165. As a point of clarification, the phrase "including" suggests there might be other types of outpatient hospital facilities that qualify for these services other than those with the provider-based status. The preamble only discusses hospitals, facilities on hospital campus, and facilities with provider-based status. If there are other types of facilities that qualify, the rule language should clarify the facilities or refer back to the ones discussed in the preamble. Secondly, the term "meets the standards for provider-based status" suggests that the State might have the discretion to make that determination even if the hospital has not made or received a written determination from Medicare. For administrative simplification and operational ease, the rule should clearly state that the "entity has been determined by CMS to have provider-based status" so that States can refer to the CMS determination.

Definition of "Clinic Upper Payment Limits"

The proposed rules go beyond requiring a comparison or limit to payments under "Medicare principles." Rather, they specify how the estimated Medicare payments are to be calculated, requiring a hospital by hospital calculation of the Medicaid payments using the Medicare CCRs as reported on the Medicare cost report. The rules dictate the specific section of the Medicare cost report that a state may use in calculating cost information for outpatient UPL, which may result in excluding Graduate Medical Education costs from the outpatient costs that a state can include.

For private clinics, states would be required to calculate UPL either by adopting reimbursement methodologies that pay a specified percentage, not greater than 100% for Medicare; or by demonstrating that in the aggregate, Medicaid fee schedule rates are less than what Medicare would pay based on a comparison by the CMS current Procedural Terminology Code. Under these requirements, states would not have the option of calculating the clinic UPL based on the clinic's actual costs since the Medicare outpatient fee schedule rates are much lower than costs.

Although Arizona has a waiver from the UPL requirements so long as our Fee-For-Service payments remain less than 5% of service expenditures, the rules should reiterate that UPL limitations do not apply to payments made through managed care entities. However, I urge you to reconsider the proposed changes to limiting Medicaid payments for outpatient hospital services. Thank you for this opportunity to comment on the proposed regulation.

Sincerely,

Thomas J. Betlach
Deputy Director